Wise Family Practice
Urgent Care

Authorizations, Release, Consents and Agreements

Consent to Treatment: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in judgements of the treating physician. I am free to ask questions about such treatment and testing. I understand that no guarantee or assurance has been made as to the result that may be obtained.

Financial Agreement: I hereby guarantee payment of services rendered. I understand that should any portion of the bill unpaid it may result in collection activity. I further understand that I will be responsible for court cost, attorney fees and agency fees which may be incurred.

Assignment of Benefits: I hereby authorize all insurance companies to pay directed to Wise Family Practice Urgent Care and an ancillary providers, any benefit and fees under my insurance policy or policies. I understand that this does not relieve me of my obligation to pay my account, co-payments and deductibles. Any balance that is not covered or paid by the insurance company is my responsibility.

Release of Medical Information: I hereby consent and authorize Wise Family Practice Urgent Care to release any medical information in connection with the services rendered for determination of benefits, or for collection of said benefits from my health insurance carrier(s) and or others parties responsible for payment. I also authorize other medical providers to release my healthcare information in connection with the services rendered for determination of benefits to Wise Family Practice Urgent Care.

Medicare Beneficiaries Only: I certify that the information given in applying for payment under the title XVII of the social securities act is correct. I authorize any holder of medical or other information about me to be released to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made directly to Wise Family Practice Urgent Care. I understand that I am responsible for health insurance deductibles and co-insurance.

Medicare Supplements: I further authorize Wise Family Practice Urgent Care to claim and receive benefits through my Medicare supplement. This authorization includes claims of Medicare benefits, authorization shall remain in effect and unless revoked in writing.

CCM Policy: I agree to enrollment into the Chronic Care Management Program which includes 24/7 access to a care provider to help with your chronic healthcare needs. A comprehensive plan of care for health needs, coordination with both home and community-based service providers, transition management among health care providers, including referrals, and follow-up after discharges from hospitals, or other health care facilities, medication oversight and management.

ABN Policy: Medicare does not cover all services in full provided by our office. I understand that I may have non-covered charges and will be financially responsible for payment. This represents an Advanced Beneficiary Notice.

I have read the authorizations, consents and agreements and I accept the terms described above. I undersigned, as the patient or on behalf of the patient have been given the opportunity to receive and read a copy of Wise Family Practice Urgent Care's Notice of Privacy Practices.

Patient Name (printed):_____DOB: _____

Signature of patient/responsible party:_____Date: _____